Tobacco or Health: Actions for the 21st Century

Report and Documentation of the Technical Discussions
held in conjunction with the 36th Meeting of CCPDM
Dhaka, 2 September 1999

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Regional Office for South-East Asia
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Part I – Proceedings[1]

[1] Originally issued as document SEA/RC52/12 dated 5 Sept 1999

1. INTRODUCTION

The Technical Discussions on Tobacco or Health: Actions for the 21st Century were held on 2 September 1999 under the chairmanship of Dr Suwit Wibulpolprasert, Assistant Permanent Secretary for Public Health, Ministry of Public Health, Thailand. Dr H.A.P. Kahandaliyanage, Senior Assistant Secretary, Ministry of Health and Indigenous Medicine, Sri Lanka, was elected Rapporteur. During the absence of Dr Suwit, Ms Sujatha Rao, Joint Secretary, Ministry of Health and Family Welfare, Government of India, chaired the discussions. The agenda and annotated agenda (SEA/PDM/Meet.36/9.1.1 and SEA/PDM/Meet.36/9.1.1 Add.1 respectively) and the working paper for the Technical Discussions (SEA/PDM/Meet.36/9.1.2) formed the basis for the discussions.

1.1 Opening Remarks by the Director, Department of General Management, WHO/SEARO

Mr R. Spina Helmholz, Director, Department of General Management, WHO/SEARO said that the global increase in tobacco consumption, particularly in the developing world, presented a major public health concern, considering the heavy disease and economic burden in the Region. Taking cognizance of the serious health implications of the use of tobacco, the 51st session of the Regional Committee selected this subject for Technical Discussions with a view to defining a focused and collective direction for tobacco control in the Region. Mr Helmholz expressed the hope that the recommendations of the Technical Discussions, duly endorsed by the Regional Committee, would guide the Member States in employing a multi-pronged strategy for tobacco control in the Region.

1.2 Introductory Remarks by the Chairman

In his opening remarks, Dr Suwit Wibulpolprasert, Chairman, said that tobacco use posed one of the greatest public health challenges globally.

However, it was heartening to note that some countries in the Region had addressed the tobacco-related issues facing them effectively and made significant progress in containing this 20th-century scourge. He stressed that strong political will, legislation, a complete ban on tobacco advertising and social mobilization among tobacco users could be important ways in which the increase in tobacco consumption could be arrested.

1.3 Presentation by Dr (Ms) Martha Osei, Regional Adviser on Health Promotion and Education, WHO/SEARO

Ms Martha Osei, Regional Adviser on Health Promotion and Education, presented the working paper and introduced the subject. She said that the objectives of the discussions were to review the global and regional situation and to develop strategies for action in the 21st century. She recalled the various resolutions adopted by the World Health Assembly towards comprehensive strategies for tobacco control. Between 1970 and 1988, a total of 17 resolutions were adopted, all stressing effective control measures. But tobacco consumption had been on the increase, particularly in developing countries. Against this background, the World Health Assembly requested the Director-General to develop a Framework Convention in Tobacco Control, which would be a global, legally-binding instrument.

The WHO cabinet project on Tobacco Free Initiative, launched in July 1998, had adopted a fast-track approach towards the development of this Framework. The recently-adopted World Health Assembly resolution WHA52.18 provided clear guidance on the process of development and negotiation of the Framework Convention and related protocols.

Tobacco Use: Implications for Global Public Health

On tobacco production and trade, she noted the steady increase since the 1900s, particularly in developing countries. Eighty per cent of the tobacco consumed globally was produced in developing countries. Currently, several million metric tonnes of tobacco was produced globally. Over the

past decade, the share of global production by high-income countries had decreased from 30% to 15%, while that by countries in the Middle East and Asia had risen from 40% to 60%. Worldwide, tobacco consumption was increasing by about 2% annually with the biggest rise occurring in the developing countries and Eastern Europe. Of the 1.2 billion smokers globally, 800 million lived in developing countries. Tobacco killed 3.5 million people every year. By 2030, this would rise to 10 million, with 7 million deaths occurring in developing countries. The shift of the tobacco epidemic to the developing countries was obvious.

Tobacco use among women was also known to cause stillbirths, low birth weight and perinatal deaths. The linkages between tuberculosis and smoking had also been documented, with smokers infected with tuberculosis facing a greater risk of death from tobacco-related diseases than their non-smoking counterparts. Tobacco also caused considerable economic loss for all countries. Currently, the world loses US$200 billion a year with one-third of the loss being borne by the developing countries. The impact of tobacco on environmental sustainability was also significant.

Tobacco-related Morbidity and Mortality

In the South-East Asia Region, there had been a steady increase in the production and consumption of tobacco in both its smoking and smokeless forms across all sections of population groups, particularly among women, children and the poor. Tobacco products in the Region contained higher levels of nicotine and tar compared with the levels in the developed countries.

Cancers, cardiovascular diseases and emphysema were increasing, as major killers in some countries of the Region. Low literacy, high poverty levels and lack of adequate public awareness of the hazards of tobacco presented a favourable environment for a possible tobacco epidemic in the Region. Effective action to control tobacco was therefore urgently needed.

Controlling Tobacco Use in the Region

It was noted that an effective balance was needed between opportunities and challenges in the Member Countries to achieve comprehensive tobacco control. Opportunities such as existing components of national control strategies documented, effective and proven strategies and the current global movement for tobacco control would need to be maximized to achieve the desired level of reduction in tobacco consumption in the Region. But the challenges of the perceived economic value of tobacco, the huge pool of potential smokers being targeted by the tobacco industry advertisements, the lowering of the age of initiation, lack of awareness of tobacco hazards and the steady shift of the tobacco industry into the Region, should be recognized.

Significant action had been taken in most countries of the Region to tackle the menace of tobacco. A partial ban on advertisements, establishment of non-smoking islands and districts in some countries, non-smoking flights, a ban on smoking in public places were some of them. However, additional efforts and resources were urgently needed in a concerted manner and on multiple fronts.

Several legislative measures, such as comprehensive ban on advertisements of tobacco products, restriction of access to tobacco products by minors in schools, restriction on smoking at workplaces and public areas to protect people from the effects of environmental tobacco smoke, compulsory disclosure of ingredients, including nicotine levels in cigarettes, and highly visible warnings on cigarette packets and cartons could be undertaken. Increase in the real price of tobacco products to reduce consumption and make it unaffordable for poor consumers and, at the same time, increase government revenue, was an effective weapon for tobacco control.

Making Tobacco Control a Reality

Tobacco should be a priority item on the political and development agenda of countries. The leadership role of the ministries of health

cannot be overemphasized for advocacy and intensified political commitment for the participation of other sectors. A network of NGOs, institutes of excellence, training colleges, the primary health care infrastructure and poverty alleviation programmes could work in partnership with each other. Research and surveillance tended to be weak and data was hard to come by. These need to be strengthened to support tobacco control measures and to provide basic information and evidence for advocacy and policy-making. Mobilization of communities and civil society was critical for effective tobacco control measures.

2. DISCUSSIONS

- The Regional Policy Framework for Tobacco Control and the Action Plan 2000-2004 developed at a regional consultation to provide collective direction for tobacco control should be proposed for adoption by the Regional Committee for implementation by Member Countries. These documents were endorsed by the group.
- Political commitment and conviction were essential for the success of the tobacco control initiatives in the countries. It had been demonstrated that public concern motivated strong political will resulting in significant progress in tobacco control measures, as in Sri Lanka and Thailand.
- The need for countries to have focal points for tobacco control activities was emphasized. It was, however, preferable to have a network of several institutions or focal points as individuals could always become vulnerable to the manipulations of multinational cigarette companies.
- The most important strategies for tobacco control were: taxation, legislation, regulation and education with the emphasis on social mobilization.
- Some of the myths and beliefs associated with smoking in the rural, hilly areas of Nepal were that it helped to keep users warm and

provided energy in the cold weather. In the urban areas, cigarettes were associated with better self-image, stress relief and a sense of belonging to peer groups.

- The possibilities of involving different sections of society in tobacco control, such as teachers, community leaders, religious leaders, NGOs, and role models, such as sports personalities, film stars and models should be explored. The involvement of NGOs in imparting suitable training to opinion leaders in the community should be encouraged.

- Insufficient information and data on the ill-effects of smoking was one of the reasons for the low effectiveness of advocacy programmes. Meanwhile, information and documents on the strategies adopted by the multinational tobacco companies to promote sales of tobacco were becoming available; these should be used to strengthen advocacy and education for tobacco control.

- Tobacco companies marketed their products aggressively with huge budgets for sophisticated advertising campaigns. On the other hand, the health ministries had scarce resources and were therefore unable to counter these campaigns.

- Some countries had achieved a breakthrough in tobacco control through a complete ban on advertising of tobacco products and alcohol on national television. These efforts were, however, getting diluted by advertisements of tobacco products on some foreign channels, cable television networks and the foreign print media. It was extremely difficult to regulate such advertising for want of international protocols. This was an area that WHO needed to focus on as it was beyond the control of any single country.

- Since there were substantial numbers of potential smokers in the school-going and adolescent age groups, it was necessary to include strong messages against smoking and tobacco use in the school health education curriculum.

- Media involvement and support in countering tobacco advertisements by highlighting the adverse cosmetic effects of smoking on the health and personality of the smoker could be explored.
- Youth and adolescents could be reached through mass rallies, campaigns etc. They could be motivated to advocate on behalf of tobacco control with senior government leaders.
- The countries of the Region faced a heavy disease burden and had very scarce resources to combat a wide spectrum of communicable and noncommunicable diseases. As such, it was difficult to allocate adequate funds for tobacco control to make a difference. However, the use of mass media, pamphlets, booklets, and handbills etc. should be encouraged to convey the message that Tobacco kills, to the large populations in the countries of the Region.
- While several countries earned substantial revenues from tobacco taxation and excise duties, there was no policy to earmark any proportion of these revenues for tobacco control activities. However, it was seen that in some countries, such as Thailand and Nepal, a percentage of the revenue earned was utilized to sustain the tobacco control programme. WHO should strongly urge all Member States to allocate a portion of the revenue earned from tobacco advertising and taxation for tobacco control programmes.
- It had been established that tobacco caused impotence and subfertility. This message could be used as an effective counter-measure to combat tobacco advertising.
- WHO could encourage the medical community and health professionals to eschew the use of tobacco to set an example as role models for the community.
- Different approaches for reaching illiterate populations could be attempted. Especially in the rural areas, where there is no electronic media, puppet shows, radio talks, folk theatre and pop songs could be effective tools to be considered.

- Mere control of tobacco consumption might not yield the desired results. The most important and sustainable measure was the 'social vaccine' injection through intensive education to women and children. Through partnership among various sections of society, some measure of success could be achieved.
- Focused research on the prevalence, causes and effects of tobacco consumption and research related to effective strategies to reduce prevalence among adolescents, women and the poor should be undertaken.
- There was a need for solidarity among Member Countries for exchange of information and experiences on tobacco-related issues.
- While strict rules were in force for food additives and flavours, there was no regulation for the manufacture of cigarettes. It was now recognized that product regulation could be a key approach for control of tobacco.
- Governments faced difficulty in enforcing tobacco regulations due to cross-border smuggling of tobacco products.
- Due to a fall in tobacco consumption in the developed countries, there was increasing pressure from western countries to dump tobacco products in the developing world.
- Teachings in various religions were a powerful tool to advocate rejection of tobacco consumption. Religious bodies and leaders could be mobilized for educating the people in the community regarding the ill-effects of tobacco use.
- Fires caused by smouldering cigarette butts had resulted in heavy economic losses in Bangladesh.
- WHO/HQ should take up the issues and regulations on advertising and media coverage with the international media, with WTO regarding dumping and the right of countries to impose non-tariff barriers on tobacco trading and the development of media materials for wide dissemination.

- ➢ WHO should focus more on support to country efforts to establish cessation services and less on holding consultations or meetings.
- ➢ WHO/HQ should also allocate adequate resources for tobacco control. Currently, the budget is hardly US$2 million as compared to US$1000 million allocated to Roll-Back Malaria.

3. RECOMMENDATIONS

(1) The members of the Technical Discussions group should adopt the document on 'Policy Framework for Tobacco Control and Action Plan for 2000-2004' and forward it to the Regional Director for adoption by the Regional Committee.

(2) Each Member Country should constitute a national council for tobacco control with representation from government, nongovernmental organizations, tobacco control experts etc. and also take steps to develop the capacity of a network of institutions on different aspects of tobacco control.

(3) Member Countries should initiate action to develop more comprehensive country-specific strategies for tobacco control.

(4) Member Countries should initiate action to enact strong legislation, increase taxation on tobacco products, institute regulations and impart education on the ill-effects of tobacco use.

(5) Focused research on the prevalence, causes and effects of tobacco consumption and research related to effective strategies to reduce prevalence among adolescents, women and the poor should be undertaken.

(6) Nicotine should be regulated as a drug and governments should establish a mechanism to monitor its use.

(7) Strong messages about the ill-effects of smoking and tobacco use should be included in the school curriculum for adolescents.

(8) WHO should adopt a strongly-worded resolution urging all Member States to set apart a portion of the money earned from tobacco advertising and taxation for tobacco control programmes.

(9) WHO should provide all available information and data on the adverse effects of tobacco on health and the long-term economic implications of tobacco use to the political leadership in the Region for policy formulation.

(10) WHO should advocate tobacco control measures in collaboration with WTO for regulating tobacco trade.

(11) WHO should encourage medical associations and health professionals to lead, by example, by eschewing tobacco use themselves. National governments should give preference to non-smokers in recruitment for positions in government service.

(12) WHO/HQ should allocate adequate resources for tobacco control activities.

Part II – Resolution, Agenda and Working Paper

Resolution[1]

The Regional Committee,

Recalling World Health Assembly resolutions WHA31.56, WHA37.14, WHA39.14, WHA43.16, and WHA44.26 and its own resolutions SEA/RC13/R4 and SEA/RC38/R8 relating to tobacco control,

Noting with concern the increasing use of tobacco across all sections of society, its grave negative impact on the health, economy and social development of countries as well as the steady influx of multinational tobacco companies in the Region,

Recognizing the efforts made so far by Member States and the urgent need to further strengthen national tobacco control strategies, particularly to protect the health of the most vulnerable,

Having considered the recommendations emanating from the Technical Discussions on Tobacco or Health: Actions for the 21st Century, held during the 36th Meeting of the Consultative Committee for Programme Development and Management (CCPDM), and

Being mindful of the Member States' responsibilities towards the global initiative on tobacco control,

1. ADOPTS the Regional Policy Framework on Tobacco Control and the Plan of Action 2000-2004 to guide country actions for tobacco control in the Region;

[1] SEA/RC52/R7

2. URGES Members States:

(a) to constitute a multisectoral national council, including the Ministries of Health, Education, Labour, Commerce, Foreign Trade, Agriculture, Information and Broadcasting, External Affairs, Law and Finance, under the chairpersonship of the Head of State/ Government to facilitate nationwide tobacco control activities;

(b) to adopt and strengthen policies which will reduce tobacco consumption, particularly among children, women and the poor, including, *inter alia*, restricting and prohibiting advertisements and promotion of all forms of tobacco products; enforcing regulations governing the packaging, visibility and effectiveness of health warnings; increasing taxes on tobacco products; intensifying consumer education on health hazards of tobacco; undertaking cessation programmes; expanding and enforcing smoking-free areas, and conducting focused research;

(c) to dedicate a portion of taxes earned on tobacco products for tobacco control activities;

(d) to regulate nicotine not used for therapeutic purposes as a controlled drug;

(e) to actively participate in the development and negotiation of the WHO Framework Convention on Tobacco Control and related protocols in accordance with resolution WHA52.18, and

(f) to promote regional advocacy for policy change through intercountry activities, such as the South-East Asia Anti-Tobacco (SEAAT) Flame, and

3. REQUESTS the Regional Director:

(a) to facilitate the strengthening of WHO collaborating centres and other centres of excellence, as identified by the Member

States, to provide the necessary technical support in research, surveillance, and training on tobacco cessation;

(b) to continue to support Member States in their national tobacco control programmes, particularly in the areas of multisectoral policies, intercountry and interregional collaborative activities;

(c) to provide technical assistance to facilitate the participation of Member States in the development and the negotiation process on the WHO Framework Convention on Tobacco Control and possible related protocols, and

(d) to urge the WHO Director-General to advocate with WTO on the issue of tobacco trade in view of its negative implications to the Region.

Agenda[1]

1. Introduction
2. Tobacco use: Implications for global public health
   - 2.1 Production and trade
   - 2.2 Consumption and prevalence
   - 2.3 Public health impact of tobacco use
   - 2.4 Effects of environmental tobacco smoking (ETS)
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   - 3.1 Socio-cultural and economic context of tobacco
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5. Tobacco control: Actions for the 21st century
   - 5.1 Legislative measures
   - 5.2 Fiscal policies
   - 5.3 Public education and consumer protection
   - 5.4 Cessation

[1] Originally issued as document SEA/PDM/Meet.36/9.1.1 dated 26 July 1999

6. Making tobacco control a reality in South-East Asia Region
   - 6.1 Advocacy for tobacco control
   - 6.2 Political commitment
   - 6.3 Health professionals' training
   - 6.4 Multisectoral partnership
   - 6.5 Community mobilization
   - 6.6 Maximising government-NGO collaboration
   - 6.7 PHC and development programmes
7. Points for consideration
   - 7.1 Leading role of ministries of health
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   - 7.3 Development of national policies and strategies
   - 7.4 Mobilization of infrastructure and resources
   - 7.5 Research and surveillance system
   - 7.6 Participation in framework convention development process
   - 7.7 Role of WHO and other international agencies

Annotated Agenda[1]

1. INTRODUCTION

WHO's role in tobacco control. This is in the context of the Organization's constitutional mandate, advocacy through various WHA and Regional Committee resolutions, the launch of Cabinet Project on Tobacco Free Initiative (TFI) and the focus on reducing tobacco consumption globally.

2. TOBACCO USE: IMPLICATIONS FOR GLOBAL PUBLIC HEALTH

2.1 **Production and trade** in the context of globalization and growing economies thus increasing availability and accessibility. The industrial/economic growth and liberalization regime adopted by most of the developing countries provide further grounds for increased availability and accessibility of tobacco.

2.2 **Consumption and prevalence** as they relate to trends in cigarette and tobacco production/consumption in developed and developing countries among specific population groups, and the tobacco industry globally. Burden of communicable diseases and the role of tobacco – current and future.

2.3 **Public health impact of tobacco use.** Current and projected tobacco-related morbidity and mortality, the economics of tobacco

[1] Originally issued as document SEA/PDM/Meet.36/9.1.1 Add.1 dated 26 July 1999

vis-à-vis resources for health, its negative influence on global health gains.

2.4 **Effects of environmental tobacco smoking (ETS)** on non-smokers, on child health. Environmental degradation.

3. COUNTING THE COST OF TOBACCO IN SOUTH-EAST ASIA REGION

3.1 **Socio-cultural and economic context of tobacco:** The tradition of tobacco use; advent of commercial production; current trade and revenue benefits, tobacco industry shift, the oral tobacco products industry.

3.2 **Tobacco, poverty, disease burden and vulnerable groups:** Tobacco consumption in the Region, prevalence and cigarette smoking and trends. Consumption among the most vulnerable, i.e., children, women and the poor. Linkages with economies of SEAR countries on socioeconomic and current and projected tobacco-related diseases, poverty alleviation programmes.

3.3 **Tobacco and women's health:** Current scenario of women's health in the Region, role of women's involvement in tobacco production and consumption; related health impact – current and in the future.

4. CONTROLLING TOBACCO USE IN SOUTH-EAST ASIA REGION

4.1 **Opportunities:** Building on existing control measures, protecting the health of women and children among whom the prevalence rate is still low, capitalizing on the global awareness; and global and regional experiences.

4.2 **Challenges:** Tobacco industry shift and marketing strategies, trade and economic predisposing factors, inadequate nationwide

consumer awareness of the hazards of tobacco, controlling smuggling; inadequate national comprehensive tobacco strategies.

5. TOBACCO CONTROL: ACTIONS FOR THE 21ST CENTURY

Focusing on effective demand reduction measures.

5.1 **Legislative measures:** Banning advertisements and promotion, promulgation of appropriate tax laws, prominent health warnings, declaration of ingredients, restricting smoking areas, raising the legal age for tobacco purchase.

5.2 **Fiscal policies:** Increasing excise duty, increasing real price of cigarettes and tobacco products.

5.3 **Public education and consumer protection:** Focus on education for children and women, public education on the hazards of tobacco, consumer information.

5.4 **Cessation:** Community-based cessation efforts, support groups, accessibility of existing Region-relevant cessation therapies.

6. MAKING TOBACCO CONTROL A REALITY IN SOUTH-EAST ASIA REGION

6.1 Advocacy for tobacco control

6.2 Political commitment

6.3 Health professionals' training

6.4 Multisectoral partnership

6.5 Community mobilization

6.6 Maximising government-NGO collaboration

6.7 PHC and development programmes

7. POINTS FOR CONSIDERATION

7.1 Leading role of ministries of health

7.2 Adoption of Regional Policy Framework and Plan of Action 2000-2004

7.3 Development of national policies and strategies

7.4 Mobilization of infrastructure and resources

7.5 Research and surveillance system

7.6 Participation in framework convention development process

7.7 Role of WHO and other international agencies

Working Paper[1]

1. INTRODUCTION

The world has seen profound health achievements during the past 50 years. Life expectancy has increased from a global average of 48 years in the 1950s to 66 years in 1998. Many more children are now living beyond the age of five years due to effective immunization programmes. Access to basic health services, water supply and sanitation facilities by communities have significantly improved. In the midst of these positive developments, there is one area that is the cause of grave concern. Tobacco use poses one of the greatest public health challenges globally with the above health gains under serious threat.

The issue of tobacco control usually brings into conflict public health and economic interests. Nowhere in the history of public health has the push for economic gains so forcefully striven against and totally divided the global resolve for better health. At no time has a public health problem had such enormous and varied implications and yet its control thwarted by a single industry. It is against this scourge that WHO and its Member States have waged a relentless battle since the 1970s. Between 1970 and 1998, the World Health Assembly adopted 17 resolutions, all unanimously, in favour of tobacco control.

The fear of the shift of the tobacco industry to developing countries and its possible impact was first expressed in 1982 by the WHO Expert Committee on Smoking Control Strategies in Developing Countries. While urging concerted action by developing countries to control tobacco, it was emphasized that these countries are the targets of aggressive promotional campaigns by the transnational tobacco companies.

[1] Originally issued as document SEA/PDM/Meet.36/9.1.2 dated 26 July 1999

The Committee admitted that widespread smoking is a major stumbling block to the successful achievement of WHO's goal of health for all by the year 2000.

Yet, the impact of control activities on tobacco consumption has been limited. The decrease in consumption in some developed countries, such as USA, Norway, Finland, Sweden, Australia, and Canada, has been matched by corresponding increases in consumption in developing countries. Tobacco is described as the 20th century's man-made epidemic by both public health experts and world-renowned economists.

Today, WHO estimates a total of 1.2 billion smokers globally with 800 million of them living in developing countries. It is predicted that 50% of these smokers, most of whom are still in their middle age, would eventually die of tobacco-related diseases, losing 20-25 life years. Currently, an estimated 3.5 million people die every year from tobacco-related diseases. By 2020, it is estimated that tobacco-related deaths will reach 10 million with developing countries accounting for 7 million deaths. It is in response to this grave public health calamity that the WHO project on Tobacco Free Initiative was launched in July 1998. The success of this project will be determined by the resolve of all Member Countries to put public health interests before perceived economic gains and seriously work in global partnership towards a tobacco-free world. The recently-adopted World Health Assembly resolution, WHA52.18, seeks to strengthen the global resolve to curb this 20th century epidemic through the development and adoption of a legally-binding global treaty – the WHO Framework Convention on Tobacco Control.

2. TOBACCO USE: IMPLICATIONS FOR GLOBAL PUBLIC HEALTH

2.1 Production and Trade

The advent of machine-manufactured cigarettes in the late 1800s contributed significantly to cigarettes becoming the dominant tobacco product by the early 1900s. In many developing countries, tobacco was

introduced by their colonial masters. Agricultural patterns in these countries were drastically changed as farmers were encouraged to grow tobacco.

Tobacco is grown in more than 100 countries of which 80% are developing countries. Four countries, including India, account for two-thirds of the production. Globally, a total of 8.0 million metric tonnes of unmanufactured tobacco is produced every year. Approximately, 5.5 trillion cigarettes are produced each year. Over the past decades, the share of global production by high-income countries has decreased from 30% to 15% while that by countries in the Middle East and Asia has risen from 40% to 60%.

2.2 Consumption and Prevalence

Worldwide, tobacco consumption is increasing by about 2% a year, with the biggest rise occurring in the developing countries and in Eastern Europe. It is estimated that consumption by developing countries will increase to 71% by the year 2000.

The global consumption of manufactured tobacco has also increased steadily between the 1970s and 1990s reaching a total of 70 million metric tones in 1994. WHO estimates that about a third of the global adult population or 1.2 billion people are smokers. But tobacco consumption has increased most in developing countries. Smoking rates have decreased in industrialized countries since 1975 while there has been a corresponding 50% increase in low income countries. Already, 800 million of the estimated global 1.2 billion smokers live in the developing countries. By 2020, it is predicted that the transfer of tobacco consumption from developed to developing countries will be well advanced with only 15% of the world's estimated 1.6 billion smokers living in the rich countries.

For many developing countries, the issue of cigarette consumption is just a part of the problem of tobacco use. The production and use of oral tobacco, which was earlier considered traditional and on a low

scale, has turned into a multi-million dollar industry in many countries. Products such as chilum, sulpa, hookah, goza, gutka, pan and pan masala, hubble-bubble, mishri, snuf, gundi are being used more extensively in developing countries, including those in the South-East Asia Region.

2.3 Public Health Impact of Tobacco Use

The health consequences of smoking and tobacco use are manifested in two ways. First, the smoker rapidly becomes addicted to nicotine which makes it difficult for him/her to quit. Acute consequences of nicotine use include increased heart rate, blood pressure and narrowing of blood vessels.

Secondly, smoking and tobacco use cause many disabling diseases. Over 25 diseases are now known to be caused by tobacco use. Prominent among these are cancers of the lung and other organs, ischaemic heart disease and other circulatory diseases as well as respiratory diseases, such as emphysema. Casual linkages have been established between smoking by parents and paediatric diseases, such as respiratory distress syndrome and sudden infant death syndrome. Tobacco use among women is also known to cause still births, low birth weight and perinatal deaths. In Regions where tuberculosis is prevalent, such as in South-East Asia, smokers infected with TB face a greater risk than non-smokers of dying from tobacco-related disease.

The economic cost of tobacco use is considerable in all countries. The World Bank reports an annual global loss of US$ 200 billion, with one-third of the loss occurring in developing countries. At the family level, the cost of tobacco has been found to be significant. For poor families, the loss of such precious income has major health and social ramifications. It means families, particularly women and children, being deprived of education, food, clothing and health care services.

The social and emotional costs related to a breadwinner dying prematurely due to a tobacco-related disease are yet to be quantified in tangible terms. But in many developing countries, this is a major loss,

particularly for poor families. Related to this is the cost of environmental contamination and occupational hazards posed by insecticides used by tobacco farmers to protect their crops. In most developed countries, organochlorine group of pesticides, such as DDT, have been banned. Yet, most developing countries continue to import these pesticides for use in tobacco cultivation. The cost of importation and treatment of pesticide poisoning could be significant.

Current studies have also underscored the negative environmental impact of tobacco cultivation, particularly when associated with deforestation required to increase farmland and cure tobacco leaves. In some countries, as much as 10 kgs of wood is burnt to cure 1 kg of tobacco leaves. Such environmental degradation has a bearing on sustainable development.

2.4 Effects of Environmental Tobacco Smoke (ETS)

ETS is defined as the material in indoor air that originates from tobacco smoke. It is made up of toxic and carcinogenic agents which are emitted primarily from the burning cone of a tobacco product as the smoker waits to take the next puff. This emission is called side-stream smoke (SS). To some extent, ETS also consists of mainstream smoke (MS), constituents which are exhaled by the smoker.

A body of evidence on the health risks of ETS has accumulated during the past two decades, connecting exposure to ETS to the risk of mortality. ETS causes basically all the major diseases in smokers due to smoking. Passive smoking also causes respiratory diseases, ear infections, asthma and sudden infant death syndrome. WHO estimates that about 700 million children, almost half of all children worldwide, live in a home where one parent is a smoker. For ETS-related problems, the USA pays a health cost of US$ 1 billion every year. Currently, an estimated 45 000 deaths due to heart diseases each year among non-smokers are attributed to passive smoking. A further annual 4 000 deaths among non-smokers are attributed to passive smoking exposure (at work, home, social).

In the South-East Asia Region, the cost of ETS could be tremendous considering the high level of nicotine and tar content of cigarettes and the extent of smoking in enclosed working and dwelling places, coupled with the lack of knowledge of the hazards of ETS. There is therefore an urgent need to highlight strong public policies to protect workers and children from exposure to tobacco smoke.

3. COUNTING THE COST OF TOBACCO IN SOUTH-EAST ASIA REGION

3.1 Socio-cultural and Economic Context of Tobacco

Tobacco use in the traditional form has been a visible part of the Asian culture. Unfortunately, tobacco production in large commercial quantities and increasing tobacco consumption is now part of the social fabric of almost all countries in the Region. Eight out of the ten countries produced tobacco in commercial quantities totalling an estimated 1.03 million metric tonnes in 1994. Currently, over 390 billion cigarettes, including Kreteks, and 9 975 billion bidis are manufactured in the Region annually. India, Indonesia, Thailand, DPR Korea were ranked 3rd, 7th, 18th and 21st respectively among the world's 25 leading producers of unmanufactured tobacco. Although the Region is a major tobacco exporter, accounting for 6.3% of the global export, 10% of the world's unmanufactured tobacco production was consumed in Indonesia, India, Thailand and DPR Korea together.

From a recent WHO Global Status Report on Tobacco, the per adult consumption of cigarettes steadily increased from 850 sticks in 1970-72 to 1 230 in 1990-1992. The South-East Asia Region is second only to the Western Pacific Region in its consumption growth rate of 2.9%.

Considering the huge population sizes of Member Countries, these percentages translate into millions of smokers. For example, in Bangladesh, it is reported that over 15 million adult men and 5 million women smoke with India reporting an estimated 194 million men and 45 million women smokers. Thailand reports as many as 11.2 million

smokers while Indonesia is estimated to have the fourth largest number of smokers in the world.

Even under the protective ambit of parents, children are not shielded from the scourge of tobacco use. India reports 5 million children smokers while 55 000 start smoking every year. A study in 1993-1994 indicated that almost half of the over 10 000 school students between 10 and 20 years were using tobacco in different forms in Myanmar. A similar high prevalence among school children has been reported in Indonesia where over 80 000 of 260 000 school children surveyed were found to smoke. About one-tenth of them started to smoke before the age of 10 years. It is also reported that 52 000 of children under the age of 20 start smoking every year in Thailand.

These millions of children could end up as tobacco victims in the next 30 years if they are not helped to quit the habit now.

In many countries of the Region, these figures reflect only cigarette smoking. Smokeless tobacco use is reported to be gaining wider acceptance among children, both in rural and urban areas, particularly in the Indian sub-continent. *Gutka* is a generic name of a product that contains tobacco, areca nut and several other chemicals and substances. It is documented to cause cancer of the mouth and oral sub-mucous fibrosis (OSF). The dangerously high levels of tar and nicotine in tobacco consumed in the Region is a major cause of concern. In Europe, the permissible maximum level of tar is less than 12 mg/cigarette and the nicotine level ranges between 1.3 – 1.6 mg. In the Region, the tar level in cigarettes ranges between 18 and 38 mg while in bidis it could be as high as 50 mg as nicotine levels up to 3.2 mg have been reported.

Morbidity and Mortality. For many countries in the Region, limited data on tobacco-related diseases and deaths are available. But wherever data exist, they point to a gradual emergence of tobacco-related diseases which contribute significantly to the burden of noncommunicable diseases in the Region. Cancers and coronary heart disease, chronic bronchitis, chronic obstructive lung diseases as well as foetal loss and perinatal deaths are the most commonly-reported tobacco-related diseases in the Region.

For example, Thailand reports 10 000 tobacco-related lung cancer cases annually. In India, an estimated 12 million cases of cancer, heart diseases, obstructive lung diseases and respiratory tract infections are attributed to tobacco use each year. Tobacco smoking has been identified as one of the major risk factors for chronic bronchitis and obstructive lung disease in Nepal. Tobacco contributes significantly to the large number of deaths due to heart disease in Sri Lanka while an estimated 43% of cancers of all sites are attributed to tobacco use in the country.

The result of increasing tobacco consumption translates into significant numbers of deaths in the Region. WHO estimates place tobacco-related deaths in the Region for 1998 at 580 000. National figures on tobacco-related deaths are difficult to come by. However, there are indications of increasing tobacco-related mortality in countries where data exist. In 1986, Indonesia reported 57 000 tobacco-related deaths. In 1992, it increased to 172 900 deaths accounting for 21% of all deaths. Based on current tobacco consumption patterns, these figures may have significantly increased. In Thailand, tobacco-related diseases claim 42 000 lives every year.

3. 2 Tobacco, Poverty, Disease Burden and Vulnerable Groups

Tobacco consumption is increasing most rapidly among the world's poorest. The gap between the rich and poor countries has widened as poor countries spend a considerable proportion of their income on tobacco importation, consumption and management of tobacco-related diseases. High poverty levels, low literacy and lack of knowledge of the hazards of tobacco, coupled with malnutrition, heavy burden of curable infections and parasitic diseases as well as lack of access to modern health services are major influencing factors.

The South-East Asia Region has all the ingredients to engender an epidemic of tobacco-related diseases. Five out of the ten Member Countries are classified as least developed countries. The per capita GNP of most countries is still very low with most people earning less than US$ 1 a day. Although remarkable health gains have been made,

the Region still contributes significantly to the global disease burden. Yet it is among these groups that tobacco consumption is increasing.

Further, the central government expenditures on health are still very low in many countries of the Region. This constitutes less than 5% of the national budget with a greater proportion covering the cost of communicable diseases control. With the increasing emergence of tobacco-related diseases, governments would be compelled to withdraw funds to support medical care for these patients. Also, the health infrastructure in most countries is still basic, with little capacity to appropriately address the magnitude of tobacco-related diseases.

The truth about tobacco is that it breeds poverty and makes the poor even poorer. For example, a poor smoker uses about 25-30% of his income on tobacco. The presence of cheap labour is one of the key motivational factors for the shift of tobacco multinationals into the Region. At the workfront, over 80% of the workforce in the tobacco industry is made up of poor, women and children exposing themselves to extensive hazards through tobacco picking and processing. The meagre income obtained is ploughed back into addressing health-related problems acquired on the job as they usually enjoy no health insurance.

In the final analysis, it is the tobacco industry which grows richer leaving the poor poorer. In 1997, the three largest tobacco multinationals, Phillip Morris, R.J. Reynolds and British American Tobacco, made profits of US$ 65 billion.

3.3 Tobacco and Women's Health

The increasing use of tobacco among women should be a cause of major concern for the Region. Recent studies document a higher risk of tobacco-related diseases among women cigarette smokers than male smokers. Women who smoke are at increased risk of premature menopause and impaired fertility. They also have an increased risk of cervical cancer. The association between tobacco use and low birth weight, foetal growth retardation and spontaneous abortion have been

well documented in women tobacco users. Available data also suggest that women smokers who use oral contraceptives have higher risk of heart problems.

While the health of women in the Region has improved over the last few decades, they continue to be more susceptible to malaria, tuberculosis, sexually transmitted diseases, HIV infections and noncommunicable diseases, such as diabetes, hypertension and cancer. High prevalence of anaemia and other nutritional deficiencies contribute significantly to high maternal deaths in the Region. Now, there is the danger of this fragile health situation being made worse with tobacco use.

For most countries in the South-East Asia Region, cigarette smoking caught on during the last 10-20 years in response to intensive media campaigns in the 1980s targeting women and children. Today, a significant number of women are reported to be using either cigarettes or bidis in countries such as India, Bangladesh, Nepal, Myanmar, Indonesia and Thailand.

There has been a parallel increase in the use of smokeless tobacco among women in the Region. Unfortunately, tobacco use in whatever form has serious health and socioeconomic implications. Just like male smokers, women tobacco users also suffer from tobacco-related diseases, including cancers, cardiovascular diseases, chronic bronchitis and chronic obstructive lung disease (COLD). Oral cancer is increasingly affecting women tobacco chewers. There are in addition, gender-specific problems. In addition to cancer of the breast, an increasing incidence of cervix cancer is being reported.

At the work front, women continue to be affected with tobacco-related health hazards. Women constitute more than 50% of the workforce of many cigarette and bidi-making industries in the Region. Occupational hazards, such as allergies, skin rash, nausea, dizziness and vomiting have been reported among women working in tobacco industries. Coupled with these is the "green syndrome" (allergic reaction including running nose and eye and itching skin) suffered by women in tobacco fields while picking mature tobacco leaves.

Compared to other WHO Regions, cigarette consumption among women in the Region is still low. Preventing any further increase in cigarette consumption and reducing oral tobacco use among women could be one of the most cost effective means to alleviate the double burden of disease among women.

4. CONTROLLING TOBACCO USE IN SOUTH-EAST ASIA REGION

The vision to create a tobacco-free region should be guided by the immense negative public health and economic impact of tobacco. The urgent need to maintain and strengthen the Region's health gains, particularly among the vulnerable, should be a motivational force to minimize the challenges while maximizing the opportunities.

4.1 Opportunities

National control strategies. Since the 1980s, Member Countries have introduced various control measures through legislative and fiscal policies. Legislation banning advertisement of tobacco products on national electronic media and, to a limited extent, in the print media has been enacted in almost all countries. Districts, communities and islands have been declared smoke-free. Public places and government institutions have been declared smoke-free in some countries while no-smoking flights on both domestic and international routes have been introduced by some countries. To protect vulnerable groups, such as school children, prevention of tobacco use is included in the school curriculum while the sale of tobacco products near schools are banned in some countries. Both government and nongovernmental organizations are actively involved in preventive and cessation programmes at the community level. Special taxes have been introduced to fund health promotion and tobacco control interventions in a few countries.

Unfortunately, the impact of these efforts has been limited, as reflected by the increase in tobacco consumption. The lack of comprehensive national and multisectoral control policies and strategies

are the major contributory factors. There is an urgent need for the Region to ensure the development and full implementation of comprehensive and intersectoral national policies and strategies for tobacco control.

Effective strategies. There is now a repertoire of tested and proven strategies for tobacco control. These comprise a package of promotional and educational measures, smoking cessation programmes, taxation, legislative controls on tobacco advertising, legislative and voluntary controls on smoking in public places and workplaces, and programmes to assist tobacco farmers transit to other crops. Through such a coherent and comprehensive package, Canada has been able to reduce cigarette consumption considerably.

A combination of legislative and fiscal policies, supported by intensified public education and cessation programmes for smokers, marks out the success story of Thailand. The number of smokers has steadily decreased since the mid-1970s. In 1995, just under half (49%) of adult males smoked and less than 4% of females smoked. For these strategies to be effective, they have to be introduced concurrently to maximize and reinforce the impact.

Capitalizing on global focus. The current high global focus on tobacco control and the express aim and determination of WHO to reduce tobacco consumption and its related morbidity and mortality presents a tremendous opportunity for SEAR to intensify its tobacco-control efforts.

4.2 Challenges

Economic and health gains. The perceived economic gains, government's tobacco stock holdings and the lack of a full understanding of the magnitude of the tobacco problem have been the major influencing factors for the lack of focus on tobacco control by many governments in the Region.

Population pool and customer replacement. The demographic dynamics of the Region indicate that at any point of time, approximately

500 million of the Region's population is below 25 years. Since most adult smokers start to smoke before the age of 18, this pool of young people are a target for the tobacco industry's aggressive marketing strategies. It is important, therefore, to protect this vulnerable group.

Lack of education. Most tobacco users in the Region are not aware of the hazards of tobacco. Low literacy levels are a major constraint to accessibility and effective public education programmes. The coverage of prevention programmes for children is limited due to low school enrolment, and the absence of health programmes for out-of-school children.

Product availability. Availability of the various types of tobacco products and the complex modes of their utilization constrain effective control of tobacco use.

Smuggling. Cross-border smuggling of tobacco products due to loose and poor enforcement of customs laws presents a big challenge, particularly to countries with strong fiscal policies. Strict enforcement of anti-smuggling and customs laws could help solve this problem.

5. TOBACCO CONTROL: ACTIONS FOR THE 21ST CENTURY

5.1 Legislative Measures

Ban on advertising, promotion, sponsorship. The messages and images typically associated with advertising and promotion of tobacco products convey the impression that tobacco use is desirable, socially acceptable, cool, sporty, attractive and glamorous. Young people are particularly vulnerable to the impact of advertisements.

Restrictions on advertising are essential for any effective programme to reduce the consumption of tobacco products, particularly among the youth. There is now ample evidence linking advertising and the uptake of smoking and the use of particular brands of cigarettes among children in the Region and elsewhere.

To reinforce the message and images of advertisements and to circumvent advertising laws, the tobacco industry uses promotion, brand stretching and sponsorships of various events. "Brand-stretching" is gaining a lot of ground in almost all countries of the Region, particularly in India and Thailand, where the cigarette industry uses consumer products, such as clothing, food items and electronic equipment, to promote its cigarette brands.

Disclosure of ingredients and packaging requirements. Though the tar and nicotine content of cigarettes and bidis sold in the Region are notoriously high, apart from Thailand, ingredient disclosure and limitation of tar and nicotine content laws and regulations have not been instituted. Maximum permissible limits for nicotine and tar should be set. Ingredient disclosure is a vital consumer information which should be reflected on cigarette packages and cartons of all tobacco products.

A key component of a government's tobacco control effort should be restricting packaging and regulating labelling to improve consumer education. First, package size for cigarettes should be specified by each country with retailers not having the option to sell single cigarette. Rotatory health messages should be prominently placed, both on the front and back of cigarette packets and cartons, and to cover at least one-third of the space against a white background to enhance visibility and legibility. Further requirements and restrictions regarding packaging and labelling should include prohibiting all extra information, including false and misleading claims on packages. In order to curb smuggling and improve effectiveness of fiscal policies, cigarette packs and cartons should be required to bear the tax stamp indicating the payment of statutory taxes to the government.

Restriction on access. Restricting the sale and gifting of tobacco products or presenting them as awards to minors has been one of the effective strategies to reduce exposure, initiation and consumption of tobacco use among children. In situations where mechanisms of identifying the age of the purchaser are available, retailers should be required to sell tobacco products only after ascertaining the age of the buyer.

Although sale of cigarettes to minors is prohibited in many countries of the Region, this is poorly enforced. Laws on licensing of retailers, the extensive availability and the use of hand rolled and oral tobacco products and the fact that many retailers are minors themselves compound the problem of law enforcement. The legal age at which children can buy tobacco products in the Region needs extensive review with the goal of strengthening laws and increasing the age of majority to 21 years.

Advertising at point of sale should cover the display of one sign in each approved retail outlet with the maximum size specified, showing in black and white the name of the product and price only. Counter top displays should not be permitted.

5.2 Fiscal Policies

Evidence from countries of all income levels shows that increasing the price of cigarettes is highly effective in reducing demand as well as improving government revenue. Higher taxes induce smokers to quit and prevent others from starting. They also reduce the possibility of ex-smokers returning to cigarettes and reduce consumption among continuing smokers. It is documented that on the average, a price rise of 10% on a pack of cigarettes could reduce demand by about 4% in high income countries and 8% in low and middle income countries. Children and adolescents are more responsive to price increases than adults. So, price increases would have a significant impact in reducing tobacco consumption.

Unfortunately, most countries have not been consistent in raising taxes. Currently, taxes average about half of the retail price of a pack of cigarettes. To be effective, the tax should be about two-thirds or more of the retail price of a pack of cigarettes. An increase in taxes should be uniformly applied to all types of tobacco products, from unmanufactured to manufactured. This is essential to prevent brand switching from more expensive cigarettes to cheap bidis and chewing tobaccos.

5.3 Public Education and Consumer Protection

One of the critical tools for mobilizing the community and civil society for tobacco control is education. The correlation between higher education and low consumption of tobacco has been documented in many countries. Moreover, accurate perception of health risks and personal relevance has been found to influence tobacco use. Specific educational programmes at workplaces, schools and communities, which highlight the health and economic benefits supported by cessation programmes, could help reduce the consumption of tobacco. Further, public education helps create a supportive social environment for tobacco control.

"Information shocks", such as the publication of research studies with significant new information on the health effects of smoking, have been found to effectively reduce demand among the public. For example, messages on the linkage between tobacco use and still births and male foetal wastage conveyed in consumer-acceptable language could significantly reduce oral tobacco use among women in cultures with social value for the boy child.

5.4 Cessation

It has been estimated that 25 million deaths from tobacco would be avoided in the first quarter of the century and 150 million more in the second quarter if worldwide cigarette consumption per adult could be halved by 2010. The benefits of quitting have been widely documented. Quitting before the onset of cancer or other serious diseases prevents most of the risks of death from tobacco among all ages. Other documented benefits include personal wellbeing, self-esteem as well as financial gains.

Despite these benefits, cessation programmes are limited in the Region. However, there is a large population of smokers who want to quit and have attempted to quit without support. Helping the current smokers in the Region to quit would significantly reduce projected morbidity and mortality. Support for quitting tobacco use should include

not only making cessation programmes available to the majority of these smokers but also increasing accessibility and affordability of cessation therapies. Currently, these are costly. In addition to currently-available therapies, the potential of other therapies, such as homeopathy and ayurvedic medicines, should be urgently explored.

6. MAKING TOBACCO CONTROL A REALITY IN SOUTH-EAST ASIA REGION

6.1 Advocacy for Tobacco Control

Tobacco consumption is a public health problem with serious ramifications, touching many important areas, such as the economy, agriculture, environment, employment, and finance. Effective control measures would necessarily be the outcome of intersectoral action based on a clear understanding of the magnitude of the problem and how it is influenced by sectoral roles. Advocacy would need to be carried out at all levels with the express aim of securing the commitment of policy makers, administrators, funding agencies and civil society to control tobacco.

The past five years have witnessed intensified advocacy at both regional and national levels. The significant strides made by Member Countries have been possible mainly through intense advocacy by tobacco control advocates. But the need to obtain the commitment of other sectors and civil society to control tobacco cannot be underestimated. Advocacy packages with information on the epidemiology of the problem, its socioeconomic and health costs and the experiences of effective control measures should be developed to facilitate action by decision makers. Advocacy with other sectors, donors and community leaders should emphasize the economic, environmental as well as social implications of tobacco use, such as poverty.

6.2 Political Commitment

Political commitment can be reflected in many ways. The establishment of a full-time, well-equipped and adequately resourced coordinating

unit is essential for effective implementation and monitoring of a national comprehensive tobacco control strategy. It is the first step towards a demonstrated commitment to tobacco control. In some countries, although focal points have been named, the lack of resources and added responsibility for other programmes renders focal points virtually ineffective.

A national policy and comprehensive strategy does not only demonstrate the government's commitment but could also serve as the appropriate tool to nurture the commitment and partnership with relevant sectors as well as improve resource mobilization.

6.3 Health Professionals' Training

WHO estimates that if only a small proportion of today's 1.1 billion smokers was able to stop, the long-term health and economic benefits would be immense. The critical role of health professionals has been documented in many countries, particularly in respect of facilitating cessation among smokers.

The training of medical and health professionals in the Region should cover tobacco prevention and cessation as part of training on noncommunicable diseases. Short and long-term training, supported with practical guidelines, are required to enable doctors to fulfil their vital function of assisting patients to stop smoking.

6.4 Multisectoral Partnership

The need to nurture multisectoral action based on genuine partnerships should be the guiding principle for any effective control programmes. Both formal and informal relationships based on a shared vision of a tobacco-free region and commitment to common goals of reducing tobacco and related morbidity and mortality, particularly among vulnerable groups, are needed to effectively control tobacco.

In most countries, tobacco control is seen as the responsibility of the ministry of health. The constant fear of being isolated by related

sectors, such as agriculture, commerce and economic planning, may curb the motivation of ministries of health to extend a hand of partnership to other sectors. But sustainable partnership is pivotal to the success of tobacco control programmes. The need for a deliberate plan and processes by the ministry of health, aimed at creating a favourable milieu for sustainable multisectoral partnership at all levels for tobacco control, cannot be overemphasized.

6.5 Community Mobilization

Communities are critical parties to tobacco control efforts. It is communities which grow and consume tobacco. It is they who eventually suffer from tobacco-related diseases. Mobilizing communities would involve creating a better understanding of the ill-effects of tobacco, how these influence their lives in economic and health terms and how the tobacco industry manipulates individuals and countries to grow and use tobacco products.

Support to gradually shift to other cash crops is a long-term but necessary intervention within a strategized process to reduce tobacco production. However, the immediate need is to create awareness about the hazards of tobacco use through advocacy and education for community leadership and organized groups. Experiences in Bhutan, Sri Lanka, Thailand and Maldives clearly indicate that communities have the capacity and determination to act favourably towards tobacco control if they are convinced of the health and social benefits.

6.6 Maximizing Government-NGO Collaboration

The achievements of NGOs and organized groups in the Region on advocacy, fostering community empowerment through crop substitution as well as prevention of tobacco use, public education and cessation have been tremendous. The aim is to build effective partnerships with these organizations to capitalize on their positive experiences while using their infrastructure and resources.

6.7 PHC and Development Programmes

The vast health and socioeconomic implications of tobacco use demand mainstreaming of tobacco control. The existing PHC infrastructure and programmes should be fully tapped in support of tobacco control. Development programmes, such as poverty alleviation, women's empowerment as well as basic minimum needs package, should include tobacco prevention activities.

7. POINTS FOR CONSIDERATION

7.1 Leading Role of Ministries of Health

The role of ministries of health is crucial in providing leadership for greater commitment to tobacco control, both within the health sector and among other sectors. Ministries of health can also initiate and sustain effective partnerships for addressing critical regulatory mechanisms which are beyond its purview. Information and research results would need to be widely distributed to build a favourable climate for partnerships.

7.2 Adoption of Regional Policy Framework and Plan of Action 2000-2004

Unlike other WHO regions, SEAR does not have a regional policy on tobacco control even though the Regional Committee has adopted two resolutions on the subject. A Regional Policy Framework and a Plan of Action: 2000-2004 incorporating the strategies and regulatory measures which could significantly reduce tobacco consumption in the Region has been developed through a regional consultation. The adoption of this Policy Framework and Plan of Action is critical to concerted and collective regional action for a tobacco-free South-East Asia Region.

7.3 Development of National Policies and Strategies

So far, many countries have taken significant actions to control tobacco. However, the interrelated nature of the tobacco problem demands a

coherent national policy and strategy which brings into focus the essential roles of other sectors. The experiences of countries, such as Thailand and Sri Lanka, could serve as useful starting points for countries which do not have national comprehensive strategies.

7.4 Mobilization of Infrastructure and Resources

It is now clear that to be effective, tobacco control should be an integral part of health and development programmes with the ministry of health playing a lead role. This implies a critical analysis of available infrastructure and resources with a view to maximizing on these as new ones are created or explored. It would be important to institutionalize mechanisms which maximize the use of intersectoral infrastructure and resources, and which is placed at the highest possible political level. This would be of tremendous help, particularly in the technical areas of research, training and standard setting. NGOs, health professional associations, women's groups are all affected by tobacco use and should be part of a collective effort towards tobacco control. Ministries of health would need to identify resources within its regular national budgets as well as current and future WHO collaborative and bilateral funding in support of tobacco control.

7.5 Research and Surveillance Systems

These are critical to effective planning, intervention, development and improvement as well as trend assessment. Research in priority areas needs to be undertaken. Existing legislative and fiscal policies need to be monitored while surveillance on tobacco-related diseases are incorporated into the health reporting and surveillance system.

7.6 Participation in Framework Convention Development Process

The participation of Member Countries in the working group and the intergovernmental negotiating body for the Framework Convention is critical for strengthening tobacco prevention in the Region.

7.7 Role of WHO and Other International Agencies

The advocacy and technical role of WHO has been amply demonstrated through the adoption of resolutions and support for implementation by Member Countries. Partnerships with international organizations, such as the World Bank, UNICEF and international NGOs, have mobilized critical support for WHO's Tobacco Free Initiative. The challenges ahead demand intensification of WHO advocacy, strengthening existing and catalyzing new partnerships to achieve tobacco control and the goal of a tobacco-free Region.

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